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mahp MASSACHUSETTS ASSOCIATION of HEALTH PLANS

May 27, 2010

David Morales, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th floor
Boston, MA 02116

RECEIVED
DIVISION OF HEALTH CARE
FINANCE AND POLICY
2010 MAY 27 P 4:06

Re: Proposed Regulations – All-Payer Claims Database
114.5 CMR 21.00: Health Care Claims Data Submission

Dear Commissioner Morales:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 13 health plans providing health care coverage to approximately 2.2 million Massachusetts residents, I am writing to offer our comments on the proposed regulations, 114.5 CMR 21.00 Health Care Claims Data Submissions. MAHP and its member health plans have been long-time supporters of increased health care transparency and we believe that the All-Payer Claims Database is a step in the right direction. This data should be used to drive the conversation as we look to develop long term solutions to the rising costs of health care. Greater transparency is critically important as we tackle the market power of certain providers as outlined in the Attorney General's Report on Health Care Costs Trends and Cost Drivers. While we are supportive of the database, we have some concerns, which are outlined below. We have also submitted a redlined version of the regulations with our suggestions for your review and consideration.

Timeframe, Scope of Request and Further Clarification Needed

As drafted, the data submission regulations require payers to submit information to the Division of Health Care Finance and Policy (Division) beginning on or before October 15, 2010, with subsequent submissions occurring on the 15th of each month. While our members have been submitting data to the Division through the Health Care Quality and Cost Council (HCQCC) data feed, the proposed regulations represent a significant expansion in the information required. For example, the proposed regulations require the submission of provider, pharmacy and product files, which have not been previously collected. A number of the new requirements represent data that is either not currently collected by health plans or not provided by health care providers during the claims submission and payment processes. Furthermore, there are a number of new fields within existing data feeds. The proposed regulations also require actuarial information that has yet to be specified, which will be outlined in a future bulletin. All of these additions require substantial work by the plans Informational Systems (IS) departments – many of which have already allocated time and resources to other projects and priorities for the remainder of the year.

Moreover, further clarification is needed on a number of new data requirements, some of which we have identified and outlined on the enclosed list. Questions also exist regarding what files and/or information should be encrypted prior to submission and what process will be used to encrypt the files. The Division should work with the health plans in order to develop clarity around the required data elements and the submission format prior to the regulations becoming effective. Once all outstanding confusion is resolved, the Division should allow health plans

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time to make the necessary changes to their IS systems prior to requiring the submission of data. We respectfully request that the Division extend the submission deadline until six months after the plans and the Division have agreed to the data specifications. This time is necessary for plans to reallocate resources and manage existing projects and to ensure that their data submissions comply with the Division's requests.

Additionally, given that the regulations are more comprehensive than the existing HCQCC regulations, the files will be vastly larger in size than files previously submitted. We ask that the Division confirm that the current method of submission will be able to accommodate these larger files or to consider adopting a more automated method for data submission prior to the first data submission. This approach will cut down on the time that would otherwise be needed to correct a deficient data submission and would lessen the administrative complexity that is likely to follow should the submissions commence on October 15, 2010.

Definition of Health Care Payer

Health Care Payer is defined broadly to include, "Any entity, public or private, that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services . . ." As drafted, the definition and the regulations do not specify whether this definition only applies to carriers licensed in Massachusetts, which we conclude should be the approach given that Massachusetts only has authority over entities licensed or operating in the Commonwealth. Therefore, to make this clear we recommend that the Division clarify this point in its definition by inserting "in the Commonwealth of Massachusetts after "or reimburse any of the costs of health services."

Self-Insured and Medicare Advantage Data Collection

The proposed regulations require health plans to provide data on all plan types, including self-insured plans. While we understand the importance of having a comprehensive data set, we have concerns with this requirement given that the claims data for a self-insured employer does not belong to a health plan acting as a third party administrator (TPA) or in an administrative services only (ASO) capacity. Contracts between the employer and TPA/ASO generally include provisions that prohibit data sharing. We d therefore, respectfully request that the Division reconsider its position regarding the collection of self-insured data. Alternatively, we request that the Division allow health plans additional time to provide this data, given that contracts will need to be amended to allow health plan access to the self-insured data.

Likewise, we have the same concerns with the requirement to include Medicare Advantage data given that the Centers for Medicare and Medicaid Services (CMS) may need to authorize the release of this information in advance of providing this information to the Division. We are also concerned that the collection of this data may compromise the integrity of the claims data given that these products are traditionally secondary to Medicare benefits. Additional time will be required in order to ensure that health plans are in compliance with CMS requirements pertaining to data submission and data sharing.

Penalties

Section 2.07 of the HCQCC regulations provide for a specific penalty of $1,000 per week of delay and a maximum penalty of $50,000 per year. In contrast, the Division's proposed regulations provide much broader discretion in assessing penalties and do not provide any guidance in terms of the weekly penalty amount and the annual maximum. Instead, the proposed regulations simply state that the Division will take all necessary actions to enforce the regulations. We ask that the Division reconsider this approach and incorporate the penalty provisions from the HCQCC regulations. This would provide health plans with clarity about the potential consequences for failing to comply while still providing a significant disincentive for noncompliance.

Reduction of Administrative Expense and Duplicate Data Requests

The creation of the All-Payer Claims Database could help decrease the administrative expense that is otherwise required in responding to various state agency data requests. The current approach of individual state agencies, such as the Attorney General's Office, the Division of Insurance (DOI), the Division of Health Care Finance and Policy (Division), the Executive Office of Health and Human Services (EOHHS), the Connector, the Group Insurance Commission (GIC), and MassHealth is fragmented and often duplicative. This database could go a long way in advancing the industry-wide administrative simplification efforts that are currently underway. However, given the comprehensive nature of the data being requested, we encourage the Division to work with the Administration in getting all state agencies to use the All-Payer Claims Database as the central repository for all data requests. Otherwise, these regulations will only add to the administrative costs and hours needed to response to a multitude of data requests.

Furthermore, as additional states look to create similar databases, or to the extent that they already exist in other New England states, such as Maine, Vermont and New Hampshire, we strongly urge the Division to ensure that the data being requested is similar to the data being required in other states. As these databases become more widely used, standardization across state lines could be an extremely powerful tool.

Privacy and Confidentiality Concerns

We also have concerns that the proposed regulations lack certain protections around privacy and confidentiality. Section 2.06 of 129 CMR 2.00: Uniform Reporting System for Health Care Claims Data Sets entitled: Protection of Confidentiality, states that the HCQCC "shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provision of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are 'personal data' within the meaning of that statute." A similar provision in the proposed regulations is necessary in order to include the same protections and to ensure that all data submissions and releases conform to all applicable privacy laws and regulations.

Furthermore, the Division should include other provisions within the regulations to ensure that all proprietary information remain confidential. We have provided additional recommendations in our redlined version of the proposed regulations on this point.

We also have concerns that the following appear on the public data release list instead of the restricted data release list:

Medical Claims Data Elements: National Service Provider ID (NPI) and Billing Provider Tax ID Number
Member Eligibility Data Elements: Health Care Home Tax ID Number and Health Care Home National Provider ID
Pharmacy Data Elements: Pharmacy Tax ID Number, National Pharmacy ID Number, Prescribing Physician NPI, Prescribing Physician Plan Number, Prescribing Physician License Number, Recipient PCP ID, and Billing Provider Tax ID Number
Dental Claims Data Elements: Service Provider Number and National Service Provider Number

We ask that the Division revisit the list of elements to ensure that the elements are appropriately categorized.

Repeal of Health Care Quality and Cost Council Regulations

We understand that it is the intent of the HCQCC to repeal its regulations once these regulations are promulgated. This is a necessary step in order to ensure that health plans are not responding to multiple data requests through the HCQCC regulations and the Division's regulations. We further recommend that the effective date of the Division's regulations be carefully timed to prevent any overlap with the HCQCC regulation submissions.

Conclusion

Increased health care transparency is a key step in reducing rising health care costs and educating consumers and employers about the true costs of medical care. A comprehensive and more robust data set across public and private payers and all provider types is critical to the success of developing long-term solutions. We offer our general support for the All-Payer Claims Database in order to achieve the goals of increased transparency, improved health care outcomes and reduced health care costs.

We appreciate the opportunity to offer our comments and we look forward to working with the Division on this issue.

Sincerely,

Lora Pellegrini
President and CEO

LIST OF DATA ELEMENTS NEEDING CLARIFICATION

Medical Claims Data Elements

- MC055 Procedure Code
- MC079 Product ID Number
- MC080 Reason for Adjustment
- MC094 Patient Status Code
- MC095 Coordination of Benefits/TPL Liability Amount
- MC098 Allowed Amount
- MC107 HCPCS Code
- MC110 Claim Process Date
- MC113 Payment Arrangement Type
- MC114 Excluded Expenses
- MC115 Medicare Indicator
- MC118 Referral Indicator
- MC 119 PCP Indicator
- MC120 DRG Level
- MC121 DRG Outlier
- MC122 Pseudo Claim
- MC123 Denied Flag
- MC124 Denied Reason
- MC126 Accident Indicator
- MC129 EPSDT Indicator
- MC131 Network Indicator

Member Eligibility Data Elements

- ME031 Special Coverage
- ME041 Enrollment Start Date
- ME042 Enrollment end Date
- ME044 Member Age Group
- ME035 Health Care Home
- ME036 Health Care Home Number
- ME037 Health Care Home Tax ID Number
- ME038 Health Care Home National Provider ID
- ME039 Health Care Home Name
- ME047 Member PCP Effective Date
- ME048 Member PCP Termination Date
- ME050 Member Deductible Used
- ME053 Disease Management Flag
- ME054 Eligibility Determination Date
- ME056 Last Activity Date
- ME063 Benefit Status
- ME071 Risk Pool Indicator
- ME076 Member Rating Category

- ME081 Medicare Code

Pharmacy Claims

- PC049 Prescribing Physician Plan Number
- PC050 Prescribing Physician License Number
- PC051 Prescribing Physician Street Address
- PC052 Prescribing Physician Street Address 2
- PC053 Prescribing Physician City
- PC054 Prescribing Physician State
- PC 055 Prescribing Physician Zip
- PC060 Single/Multiple Source Indicator
- PC062 Billing Provider Tax ID Number

Product File

- PR003 Product ID Number

Provider File

- PV032 Provider Network ID
- PV041 Filler

Proposed Regulation
4/15/10

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
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21.01: General Provisions

(1) Scope and Purpose. 114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to the Division in accordance with M.G.L. c. 118G. The regulations also govern the submission of data and other information concerning the costs and utilization of health care in Massachusetts and set forth the requirement for and format of the submission of data by payers. The information submitted is essential for the Division to monitor health care cost trends, minimize the duplication of data submissions by payers to state entities, and promote administrative simplification among state entities in Massachusetts.

(2) Effective Date. These regulations shall be effective on July 1, 2010.

20.02: Definitions.

The following words shall have the following meanings:

CMS. The federal Centers for Medicare and Medicaid Services.

Confidential Agency Data. Data collected or produced by Division that:

a. Has not been released publicly;
b. Is not a public recored pursuant to M.G.L. c. 4, § 7(26) and St. 2006, c. 58, § 36; and
c. Shall not, in the opinion of the Division, be released.

Confidential Clinical Data. Data provided to the Division that:

a. Has not been revealed to the general public; and
b. Relates to the provision of medical or other services to a specific individual.

Confidential Financial Data. Data provided to the Division that:

a. Has not been revealed to the general public; and

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
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b. Would directly result in the data provided being placed at a competitive economic disadvantage; and
c. Shall not, in the opinion of the Division, be released.

Division . The ~~Division of~~Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Health Care Claims Data. Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to the ~~Division.~~Division.

Health Care Payer ("Payer") Any entity, public or private, that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services in the Commonwealth of Massachusetts, and includes without limitation an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, and a medical service corporation.~~; third-party administrators, and self-insured plans, to the extent allowable under federal law governing health care provided by employers to employees or any other entity arranging for or providing health coverage.~~

Member Eligibility File. A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates, and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.

Member. A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.

Provider. A health care practitioner, health care facility, health care group, medical product vendor or pharmacy.

Public Use Files. Datasets containing records derived from records submitted by payers under this regulation. Public Use Files contain de-identified member and utilization data elements and exclude payer identifiers

Restricted Use Files. Datasets containing records derived from records submitted by payers under this regulation. Restricted Use Files contain data elements that may not be disclosed unless the Division determines that an applicant fulfills the requirements imposed by 114.5 CMR 22.03.

Third-Party Administrator. Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, residents of the state on

behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer.

21.03: Information and Data Submission Requirements

(1) General.

a. The ~~Division will~~Division will provide specifications for all submissions described in this regulation by Administrative Bulletin and updated from time to time in accordance with 21.05, including file specifications, file submission schedules, thresholds, and reference tables.

b. Health Care Payers shall submit the information described in sections 21.03(2) and 21.03(3) according to 'Schedule A' as determined by the Division by Administrative Bulletin. Public Health Care Payers' obligation to submit information is limited to the information listed in M.G.L. c. 118G, § 6, subject to any applicable federal law. Public Health Care Payers may provide additional information pursuant to interagency service agreement(s) entered into with the ~~Division~~ Division, subject to applicable federal law.

c. Health Care Payers shall submit data sets described in section 21.03.(4) on a monthly basis; except that plans with fewer than 2,000 enrolled lives may opt to submit on a quarterly basis upon advance notice to the Division .

   i. Monthly claims files are due to the ~~Division by~~Division by the fifteenth day of the following month. For example, files containing medical claims, pharmacy claims and member eligibility data for services paid during January should be submitted on February 15.

   ii. Quarterly reports are due on the last day of the month after the calendar quarter closes; for example the report for files containing medical claims, pharmacy claims and member eligibility data for services paid during the first quarter of the calendar year should be submitted by April 30.

d. At the ~~Division 's~~Division's request, Health Care Payers must submit additional information necessary to ensure that the ~~Division has~~Division has complete and accurate information based on the information in the payer's possession and shall be limited to information listed in M.G.L. c. 118G, § 6, subject to any applicable federal law.

e. Failure to conform to the requirements set forth by the ~~Division for~~Division for submission may result in the rejection and return of the applicable data file(s). All rejected and returned files must be

resubmitted in the appropriate, corrected form to the Division-, or its designee, within 10 days.

(2) Private Health Care Plan Information. All private Health Care Payers shall provide data and information for all plan types, ~~including self-insured plans~~, as further specified by Administrative Bulletin, including but not limited to the following:

a. individual and family plan premiums for a representative range of group sizes, and annual individual and family plan premiums for the lowest cost plan in each group size for every plan with at least 1,000 Massachusetts residents that meets the minimum standards and guidelines established by the Division of insurance under section 8H of chapter 26, organized by product codes that also appear in the Member Eligibility File;
b. information supporting the actuarial assumptions that underlie the premiums for each plan;
c. summaries of the plan designs for each plan;
d. medical and administrative expenses by market sector, including medical loss ratios for each plan;
e. information regarding the payer's current level of reserves and surpluses; and
f. information on provider payment methods and levels, including but not limited to total amounts and specific capitated payments, risk sharing arrangements and settlements, and any other provider payments made outside the automated or manual claims payment system.

(3) Publicly Supported Health Care Plan Information (including MassHealth Managed Care Organizations): All publicly supported Health Care Payers shall provide data and information further specified in Schedule A or by Administrative Bulletin which includes but is not limited to the following:

a. per-member per-month premiums for enrollees in publicly supported Managed Care Organizations and the actuarial assumptions that support such premiums;
b. summaries of plan designs and covered services for each plan;
c. information concerning the medical and administrative expenses, including medical loss ratios for each managed care organization and program;
d. information regarding a managed care organization's current level of reserves and surpluses; and

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
MAHP REDLINED EDITS

e. information on provider payment methods and levels, including payment methodologies.

(4) Health Care Data – Medical Claims, Member Eligibility, Pharmacy Claims, Dental Claims

a. Health Care Payers shall provide health care data described in this section, and as further specified in Schedule A or by Administrative Bulletin.

b. Claims and Encounter Data. Health Care Payers must provide claims-line detail for all health care services provided to Massachusetts residents, whether or not the health care was provided within Massachusetts. Such data shall include but is not limited to fully-insured ~~and self-funded accounts~~ and all commercial medical products for all individuals and all group sizes.

1. Health Care Payers must report health care service claims and encounters for all Massachusetts resident members, and all members of a Massachusetts employer group including those who reside outside of Massachusetts. Payers must identify encounters corresponding to a capitation payment.

2. Health Care Payers must provide data and information for payments and financial transactions that do not utilize the claims system, including but not limited to:
   a. encounters;
   b. amounts withheld for any reason;
   c. claims associated with risk-sharing arrangements
   d. paper-based claims;
   e. pay-for-performance payments and
   f. claims not otherwise described.

3. Expenses associated with cost containment or medical management efforts should be reported separately according to the requirements in section 114 CMR 21.03 (2) and (3).

4. Each submitted data file shall have control totals and transmission control data.

a. Health Care Payers must provide information according to the ~~Division 's~~Division's specifications to identify the type of service and setting in which the service was provided.

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
MAHP REDLINED EDITS

c. Member Data: Health Care Payers must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from product, pharmacy, dental and medical claims data sets.

d. Provider listings: Health Care Payers must provide a file that includes standard identifiers such as provider name and locations, and standard identifier codes such as NPI, for hospital based services, ambulatory care, specialty providers and pharmacy providers.

e. Pharmacy claims: Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid.

f. Dental data: Health Care Payers must provide data containing all dental claims and encounters data for members.

g. Product File: Health Care Payers must provide detailed information on covered services, group size, coverage levels, and copayments.

21.04 Penalties.

If any payer fails to submit required data to the Division on a timely basis, or fails to correct submissions rejected because of excessive errors, the Division or its designee shall provide written notice to the payer or health care claims processor. If the payer or health care claims processor fails, without just cause, to provide the required information within 2 weeks following receipt of said written notice, the Division may require the carrier to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum penalty under this section shall be $50,000 per year. The Division, through Administrative Bulletin, shall include the standards that the Division or its designee will use to assess penalties for failure to submit required data, and shall define "just cause" for delays in providing required data.

~~If any payer fails to submit required data to the Division on a timely basis, or fails to correct submissions rejected because of errors, the Division or its designee shall provide written notice to the payer. If the payer fails to provide the required information within 2 weeks following receipt of said written notice, the Division will take all necessary steps to enforce this provision to the fullest extent of the law. The Division may grant an extension of time for just cause. Any~~

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
MAHP REDLINED EDITS

~~remedy available in this section is in addition to any sanctions and penalties that may apply under the provisions of any other state entity, to the extent that the Division collects information on behalf of such other entity or entities.~~

21.05: Confidentiality and Liability

1. The Division shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, the Division shall ensure that any contract entered into with other parties for the purposes of processing and analysis of data collected under 114.5 CMR 22.00 shall contain assurances that such other parties shall also comply with the provisions of M.G.L. c. 66A.
2. Data collected pursuant to M.G.L. c. 118G, §§6, 6½ are not a public record as defined by M.G.L. c. 66, c.66A, and c. 4, §7.
3. Health Care Payers shall not be liable for the inappropriate release of proprietary or confidential data or data security breaches made by the Division or any third party with whom the Division contracts in connection with the activities of the APCD.
4. The Commissioner shall be responsible for ensuring data integrity and security and shall enter into *Data Use and Reciprocal Support Agreements* (DURSA) with Health Care Payers. Such agreements shall clearly identify each party's responsibilities and financial liability should a security breach occur.
5. The Commissioner shall ensure that patient privacy will be protected as required by state and federal laws, including HIPAA.
6. The following information submitted by Health Care Payers shall be regarded as confidential and shall not be released in either the public use or restricted use data files:
    a. Data as it relates to the Health Care Payer's corporate plan or reorganization;
    b. Data that contains either a trade secret or contract information that would, if revealed, substantially and adversely affect the ability of the Health Care Payer, its affiliated interests or the other persons or entities with which the Health Care Payer is engaging in a joint venture or commercial action to compete with other entities offering or proposing to offer the same goods and services in the same market;
    c. Data that would, if revealed, substantially and adversely affect the ability of the Health Care Payer or its affiliated interest to obtain financing on reasonable terms in competition with others seeking similar types of capital;

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114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
MAHP REDLINED EDITS

d. Data that could lawfully be concealed under applicable laws governing financial transactions; and
e. Data that is restricted under a confidentiality agreement between the Health Care Payer and its business partner(s).

7. Disclosure of claims data collected under 114.5 CMR 21.00 is governed by 114.5 CMR 22.00.

~~(1) Data collected pursuant to M.G.L. c. 118G, §§6, 6½ are not a public record as defined by M.G.L. c. 66, c.66A, and c. 4, §7.~~
~~(2) Disclosure of claims data collected under 114.5 CMR 21.00 is governed by 114.5 CMR 22.00.~~

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21.06: Testing of Files

At least 30 days prior to the initial submission of the files, each payer shall submit to the Division, or its designee, a data set for determining compliance with the standards for data submission. The size, based upon a calendar period of one month, or quarter of the data files submitted shall correspond to the filing period established for that payer.

21.076: Severability

The provisions of 114.5 CMR 21.00 are severable and if any such provisions or the application of such provisions to any applicant or circumstances are held invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or unconstitutionality of any of the remaining provisions of 114.5 CMR 21.00 or of such provisions to an applicant or circumstances other than those as to which it is held invalid.

114.5 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
114.5 CMR 21.00 HEALTH CARE PAYER CLAIMS DATA SUBMISSION
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Schedule A

Schedule for Data Submissions: Unless otherwise directed by the ~~Division~~ ,Division, Payers shall submit information to the ~~Division in~~Division in the specified format in accordance with the following schedule:

(1) On or before ~~October~~ April 15, ~~2010~~ 2011 and thereafter on the 15th of each month, files described in section 114.5 CMR 21.03(4) for claims incurred during the prior calendar month.

(2) On or before ~~October~~ April 15, ~~2010~~2011, files described in section 21.03(4) containing claims, member eligibility, provider directory and product information for the period of January 1, 2008 through December 31, 2009.

(3) On or before, October 15 of each year, beginning in calendar year 2011, files described in section 21.03 (1),(2) and (3) containing information about the plan for the prior calendar year.